

FILED JUL 20 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **23472**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 167 PRIMARY REG. DIST. NO. 5607 Registrar's No. 212

510

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY <u>Johnson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Johnson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Rural, Kingsville</u>		c. CITY OR TOWN <u>Kingsville,</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>76yrs</u>		e. STREET ADDRESS (If rural, give location) <u>Route #1, Kingsville, Mo.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>at Home, Route #1, Kingsville</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Martha</u>	b. (Middle) <u>Isabelle</u>	c. (Last) <u>Ballard</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>July 7 1954</u>
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5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 14, 1877</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>23</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>State of Kentucky</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Patrick Henry Lawson</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Ann Hall</u>	14. NAME OF HUSBAND OR WIFE <u>Samuel E. Ballard</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>XXXX</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Willis Carlson, Tarkio, Mo.</u>	ADDRESS <u>Tarkio, Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		<u>3 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>Arterial Hypertension</u>		<u>Approx 10 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes Mellitus</u>		<u>7 yrs</u>	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>331X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from July 5, 1954, to July 7, 1954, that I last saw the deceased alive on July 6, 1954, and that death occurred at 3:00 pm., from the causes and on the date stated above.

23a. SIGNATURE <u>E. F. Slaughter, MD</u>	(ID name or title) _____	23b. ADDRESS <u>Odessa, Mo</u>	23c. DATE SIGNED <u>7/8/54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>7/11, '54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Elm Spring Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Kingsville, Missouri.</u>
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DATE REC'D BY LOCAL REG. <u>July 10, 1954</u>	REGISTRAR'S SIGNATURE <u>Mrs. H. V. Redford</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Canaway and Ropp</u>	ADDRESS <u>Holden, Missouri</u>
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RECEIVED  
JUL 12 1954  
JOHNSON COUNTY HEALTH DEP

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ..... Student Embalmer No. .... working under my personal supervision.

Student.....  
Signature of Student Embalmer

Signed.....  
*M. R. Crassey*

Licensed Embalmer No. .... *134*

P. O. Address.....  
*Holden*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.